3 Pathology Guidelines

3.1 Introduction

3.1.1 General Policy

This section covers all Medicaid services provided by laboratories as deemed appropriate by the Department of Health and Welfare (DHW). It addresses the following:

- Claims payment.
- Prior authorization (PA).
- Healthy Connections (HC).
- Laboratory coverage and requirements.
- Claims billing.

See *Section 2.3 Prior Authorization (PA)*, *General Billing Information*, for more information on billing services that require PA.

3.1.2 Prior Authorization (PA)

Some pathology/laboratory services require PA. Please contact EDS to verify if the procedure requires PA at:

(208) 383-4310 in the Boise calling area
(800) 685-3757 (toll free)

Note: EDS is not an authorizing agency for any Medicaid services and does not issue PAs.

If a PA is required, the PA number must be included on the claim form in the appropriate field, or the service will be denied.

3.2 Laboratory Coverage

3.2.1 Independent Laboratories

Independent laboratories are not affiliated with a specific physician's office and must have a separate provider number. They may provide testing for multiple groups of physicians. However, independent laboratories must bill Idaho Medicaid directly for the services they render.

Independent laboratories must hold a current Clinical Laboratory Improvement Amendments (CLIA) certificate before Medicaid will reimburse for testing performed in the laboratory. Payments may be denied to any laboratory submitting claims for services not covered by a CLIA certificate and for services rendered outside the effective dates of a CLIA certificate. A current CLIA certificate must be on file with EDS.

3.2.2 Laboratory Procedures

Only the following CPT lab codes can be broken out into a professional and technical component:

- **88104** - **88125**
- **88160** - **88162**
- **88172** - **88173**
- **88182**
- **88300** - **88319**
- **88323**
- **88331** - **88334**
- **88342** - **88368**
- **88385** - **88386**

Pathologists who own an office/laboratory and equipment may be paid for the complete test. This includes tests that cannot be broken out into the professional and technical components.

3.2.3 Diagnosis Code

Always indicate a valid diagnosis code on the claim form. If the correct diagnosis is unavailable, enter ICD-9-CM diagnosis code **V72.6 –** Laboratory examination, for the primary diagnosis in field **21** on the CMS-1500 claim form or in the appropriate field of the electronic claim form. For participants enrolled in the Pregnant Women (PW) or Presumptive Eligibility (PE) Programs see *Section 3.2.6 Presumptive Eligibility (PE)/Pregnant Woman (PW) Services*.

3.2.4 Venipuncture

Use procedure code **36415** for routine venipuncture and collection of specimens.

3.2.5 Special Services

Handling and conveyance of specimens for transfer to a laboratory from place of service **12** (Residence) or **32** (Nursing Home) are covered by Medicaid when billed with procedure code **99001**.

3.2.6 Presumptive Eligibility (PE)/Pregnant Woman (PW) Services

Services rendered to Medicaid participants eligible for the PE or PW Programs must have a pregnancy diagnosis or documentation to substantiate how the service was pregnancy related. When in question, the laboratory provider should include a signed Medical Necessity form (pregnancy related) from the referring physician with their claim form.

For more information on PE and PW see *Section 1.4 Benefit Plan Coverage, General Provider and Participant Information*. Providers can obtain the pregnancy related Medical Necessity form in *Appendix D; Forms*.

3.2.7 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

Federal requirements mandate that all Medicaid eligible children ages 12 months and again at 24 months be tested for lead poisoning. The U.S. Centers for Disease Control (*Preventing Lead Poisoning in Young Children*, October 1991) no longer recommends the use of erythrocyte protoporphyrin (EP) for blood lead level testing. Idaho Medicaid follows the American Academy of Pediatrics periodicity schedule.

3.2.8 Place-of-Service (POS) Codes

Enter POS code **81** when billing for services in an independent laboratory.

3.2.9 Modifiers

When a repeat procedure is ordered on the same day, for the same participant, report with modifier **91**.

3.3 Claim Billing

3.3.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

All claims must be received within 12 months (365 days) of the date of service.

3.3.2 Electronic Claims

For PES software billing questions, consult the *Provider Electronic Solutions (PES) Handbook*. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software. *Section 2.2.1 Electronic Claims Submission, General Billing Information,* for more information.

3.3.2.1 Guidelines for Electronic Claims

Provider Number: In compliance with HIPAA and the National Provider Identifier (NPI) initiative beginning May 24, 2008, federal law requires the submission of the NPI number on all electronic 837 transactions. Idaho Medicaid recommends providers obtain and register one NPI for each Medicaid provider number currently in use. It is recommended that providers continue to send both their Idaho Medicaid provider number and their NPI number in the electronic 837 transaction. Electronic 837 claims will not be denied if the transaction is submitted with both the NPI and the Idaho Medicaid provider number.

Detail Lines: Idaho Medicaid allows up to 50 detail lines for electronic HIPAA 837 Professional transactions.

Prior Authorization (PA) Numbers: Idaho Medicaid allows more than one PA number on an electronic HIPAA 837 Professional transaction. A PA number can be entered at the header or at each detail of the claim.

Modifiers: Up to four modifiers per detail are allowed on an electronic HIPAA 837 Professional transaction.

Diagnosis Codes: Idaho Medicaid allows up to eight diagnosis codes on an electronic HIPAA 837 Professional transaction.

National Drug Code (NDC) Information with HCPCS and CPT Codes: A corresponding NDC is required on the claim detail when medications billed with HCPCS codes are submitted. See *Section 3.18.6.3* of the *Physician Guidelines,* for more information.

Electronic Crossovers: Idaho Medicaid allows providers to submit electronic crossover claims for professional services.

3.3.3 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

All dates must include the month, day, century, and year.

Example: July 4, 2006 is entered as 07042006

3.3.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.

- When using a printer, make sure the form is lined up correctly so it prints evenly in the appropriate field.
- Keep claim form clean. Use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MMDDCCYY) format. **Note:** In field **24A** (From and To Dates of Service) there are smaller spaces for entering the century and year. Refer to specific instructions for field **24A**.
- You can bill with a date span (From and To Dates of Service) only if the service was provided every consecutive day within the span.
- A maximum of six line items per claim can be accepted. If the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- Be sure to sign the form in the correct field. Claims will be returned that are not signed unless EDS has a signature on file.
- Do not use staples or paperclips for attachments. Stack the attachments behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).
- Only one PA is allowed for paper claims.
- When billing medications with HCPCS/CPT codes an NDC Detail Attachment must be filled out and sent with the claim.

3.3.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:
EDS
PO Box 23
Boise, ID 83707

3.3.3.3 Completing Specific Fields of CMS-1500

Consult the, Use column to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid Program are shown on the following table. There is no need to complete any other fields. Claim processing will be interrupted when required information is not entered into a required field.

The following numbered items correspond to the CMS-1500 claim form.

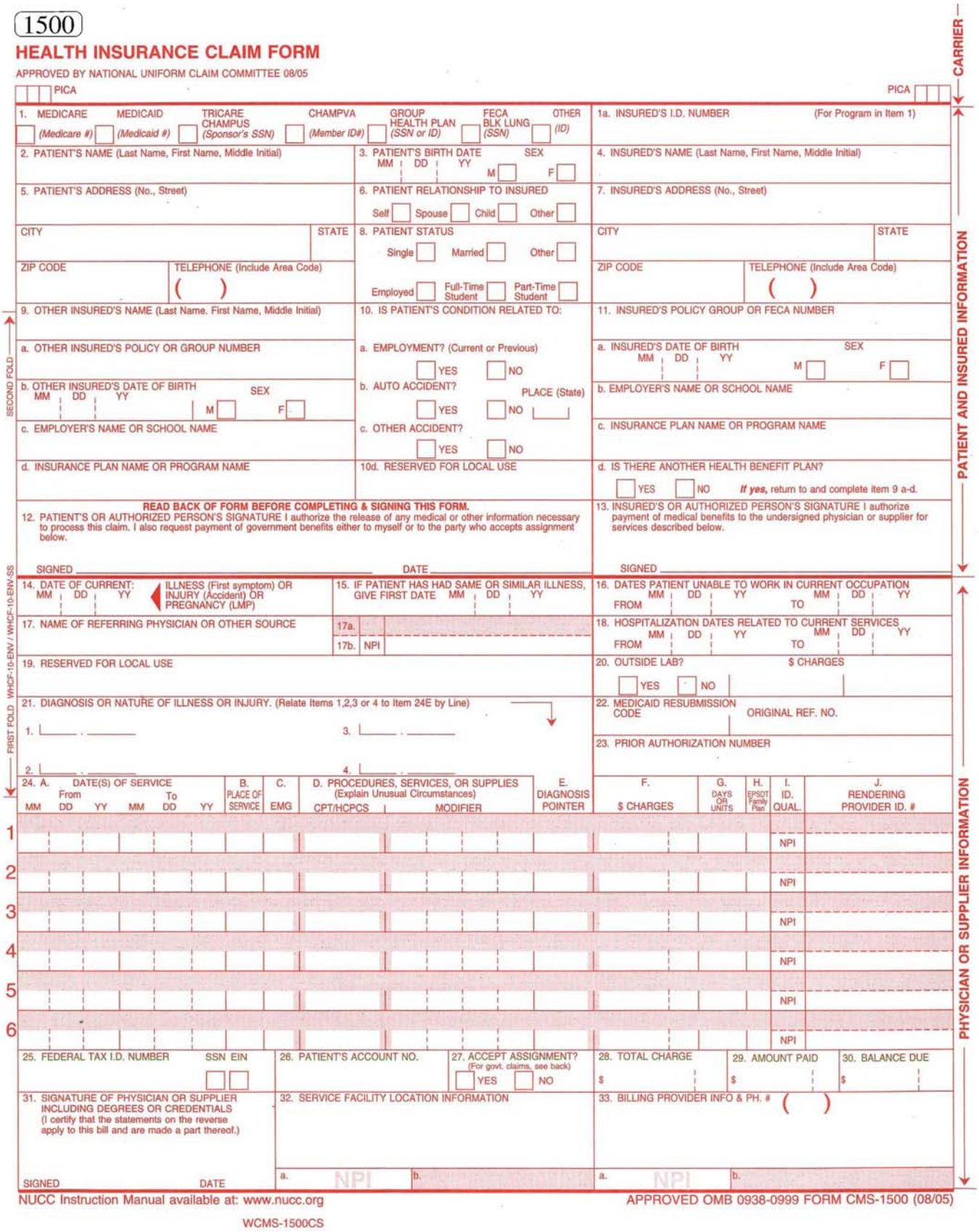
Note: Claim information should not be entered in the shaded areas of each detail unless specific instructions have been given to do so.

Field	Field Name	Use	Directions
1a	Insured's ID Number	Required	Enter the 7-digit participant Medicaid identification (MID) number exactly as it appears on the MAID card.
2	Patient's Name (Last Name, First Name, Middle Initial)	Required	Enter the participant's name exactly as it is spelled on the MAID card. Be sure to enter the last name first, followed by the first name, and middle initial.
9a	Other Insured's Policy or Group Number	Required, if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the policy number.
9b	Other Insured's Date of Birth/Sex	Required, if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	Employer's Name or School Name	Required, if applicable	Required if field **11d** is marked yes.

Field	Field Name	Use	Directions
9d	Insurance Plan Name or Program Name	Required, if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Condition Related to Employment?	Required	Indicate Yes or No, if this condition is related to the participant's employment.
10b	Is Condition Related to Auto Accident?	Required	Indicate Yes or No, if this condition is related to an auto accident.
10c	Is Condition Related to Other Accident?	Required	Indicate Yes or No, if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check Yes or No, if there is another health benefit plan. If yes, return to and complete items **9a** - **9d**.
14	Date of Current: Illness, Injury or Pregnancy	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness Give First Date	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required, if applicable	Use this field when billing for a consultation or HC participant. Enter the referring physician's name.
17a	Blank Field	Required, if applicable	Use this field when billing for consultations or HC participants. For consultations enter the qualifier **1D** followed by the referring physician's 9-digit Idaho Medicaid provider number. For HC participants, enter the qualifier **1D** followed by the 9-digit HC referral number. **Note**: The HC referral number is not required on Medicare crossover claims.
17b	NPI	Not Required	Enter the referring provider's 10-digit NPI number. **Note:** The NPI number, sent on paper claims, will not be used for claims processing.
19	Reserved for Local Use	Required, if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the Internal Control Number (ICN) of previous claims to establish timely filing.
21 (1 - 4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate ICD-9-CM code (up to four for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.
23	Prior Authorization Number	Required	If applicable, enter the PA number from Medicaid, DHW, RMS, ACCESS, RMHA, QIO, or MT.
24A	Date of Service — From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). Example: November 24, 2003 becomes 11242003 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the POS field on the claim.
24C	EMG	Required, if applicable	If the services performed are related to an emergency, mark this field with an X.

Field	Field Name	Use	Directions
24D 1	Procedures, Services, or Supplies CPT/HCPCS	Required	Enter the appropriate 5-character CPT or HCPCS procedure code to identify the service provided.
24D 2	Procedures, Services, or Supplies Modifier	Desired	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as four. Otherwise, leave this section blank.
24E	Diagnosis Pointer	Required	Use the number of the subfield (1 - 4) for the diagnosis code entered in field **21**.
24F	$ Charges	Required	Enter the usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H	EPSDT Family Plan	Required, if applicable	Not required unless applicable. If the services performed constitute an EPSDT program screen, see *Section 1.6 EPSDT*, for more information.
24I	ID. Qual.	Required, if Legacy ID	Enter qualifier **1D** followed by the 9-digit Idaho Medicaid provider number in **24J**.
24J	Rendering Provider ID #	Required, if applicable	Enter the 9-digit Idaho Medicaid provider number in the shaded portion of this field if the **1D** qualifier was entered in **24I**. **Note:** If the billing provider number is a group, then paper claims require the 9-digit Idaho Medicaid provider number of the performing provider in the Rendering Provider ID # field. **Note:** Taxonomy codes and NPI numbers, sent on paper claims, will not be used for claims processing.
28	Total Charge	Required	The total charge entered should be equal to all of the charges for each detail line.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance including Medicare. Attach documentation from an insurance company showing payment or denial to the claim.
30	Balance Due	Required	Balance due should be the difference between the total charges minus any amount entered in the amount paid field.
31	Signature of Physician or Supplier Including Degrees or Credentials/Date	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See *Section 1.1.4 Signature-on-File Form*, for more information.
33	Billing Provider Info & PH #	Required	Enter the name and address exactly as it appears on the provider enrollment acceptance letter or Remittance Advice (RA). **Note:** If you have had a change of address or ownership, immediately notify Provider Enrollment, in writing, so that the Provider Master File can be updated.
33A	NPI	Desired, but not required	Enter the 10-digit NPI number of the billing provider. **Note:** NPI numbers, sent on paper claims are optional and will not be used for claims processing.
33B	Blank Field	Required	Enter the qualifier **1D** followed by the provider's 9-digit Idaho Medicaid provider number. **Note:** All paper claims will require the 9-digit Idaho Medicaid provider number for successful claims processing.

3.3.3.4 Sample Paper Claim Form



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name. First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH. # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS